EXHIBIT A

United States Medical Licensing Examination®

Guidelines

General Guidelines to Request Test Accommodations

The following general guidelines are applicable to all disabilities and are provided to assist you in documenting a need for test accommodations based on an impairment that substantially limits one or more major life activities.

Requests for accommodations must include the following:

1. A completed and signed Request for Test Accommodations form

- Follow the instructions to initiate a request for accommodations.

2. A personal statement

3. A report of professional evaluation and/or appropriate records from a qualified evaluator/treating professional

4. Relevant objective records of impaired functioning

Additional Guidelines for Specific Impairments

Specific Learning Disorders

- **Attention-Deficit/Hyperactivity Disorder (ADHD)**
- **Visual Impairments**
- **Hearing Impairments**
- **Psychiatric Disorders**

ALL Supporting documentation must be clear, legible and complete

In This Section

electronic form (e.g., PDF files must be easily readable).

- Reports and correspondence from professionals must be typewritten on official letterhead, dated, and signed by the professional. Handwritten or unsigned letters from physicians or evaluators will not be accepted.
- Provide certified English translations of non-English documentation.
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Supplemental Documentation

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informed decision and you will be offered the opportunity to supplement your request and supporting documentation.

Reconsideration

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Test Accommodations

Reschedule an Exam

USMLE Updates & Research

Performance Data

Podcasts

Privacy

United States Medical Licensing Examination®

Guidelines

General Guidelines to Request Test Accommodations

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2. A personal statement

- Provide a written statement describing the disability for which you are requesting accommodations.
  - Include specific information about the disability-related symptoms and how they affect your academic, occupational, social and other important areas of functioning.
  - Describe the extent to which your daily functioning is impaired and how that impairment interferes with your ability to access the examination under standard conditions.
  - Provide a clear rationale for the requested accommodation(s) and describe how each requested accommodation will alleviate the functional limitations caused by your disability.

3. A report of professional evaluation and/or appropriate records from a qualified evaluator/treating professional

4. Relevant objective records of impaired functioning

Additional Guidelines for Specific Impairments

Specific Learning Disorders

Attention-Deficit/Hyperactivity Disorder (ADHD)

Visual Impairments

In This Section

Psychiatric Disorders

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Announcements

Common Questions

Step Exams

Step 1

Step 2 CK

Step 3

Test Accommodations

Reschedule an Exam

USMLE Updates & Research

Performance Data

Podcasts

Privacy

United States Medical Licensing Examination®

Home - Step Exams - Test Accommodations

Guidelines

General Guidelines to Request Test Accommodations

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2. A personal statement

3. A report of professional evaluation and/or appropriate records from a qualified evaluator/treating professional

- Documentation from the evaluating or treating professional should be comprehensive and provide specific evidence of impairment.
- In most cases, the professional evaluation should have been conducted within the past **three years**. More recent documentation may be necessary for relapsing-remitting conditions or conditions that can change as a result of time or treatment (e.g., visual, neuromuscular, psychiatric impairments).
- The evaluating professional should have training and direct experience in the diagnosis and treatment of adults in the specific area of disability.
- The diagnostic methods used should be appropriate to the specific disability and current professional practices within the field. The evaluation report should adhere to current professional standards.

- The qualified professional should provide their full name, professional credentials, current title, mailing address, e-mail address, and telephone number.
- A comprehensive report of evaluation should include:
  - A description of the onset, frequency, intensity, and duration of relevant symptoms as well as the extent to which the symptoms impact your daily functioning across multiple environments (e.g., social, academic, occupational, etc.).
  - A statement of the presenting problem and background history.
  - A description of the assessment procedure as well as specific diagnostic tests administered.
  - A detailed analysis and interpretation of the findings.
  - Actual results (e.g., scores) of all diagnostic procedures and tests utilized in the evaluation.
  - If a diagnosis is indicated, the evaluator should describe a professionally recognized diagnosis based on criteria outlined in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Statistical Classification of Diseases and Related Health Problems (ICD).
  - A description of the full extent of the individual's functional limitations due to the disability and how it impacts the individual's access to the examination under standard testing conditions.
  - A description of the functional impact on physical, perceptual, and cognitive abilities in the context of the specific examination setting and format (e.g., computer-based examination; clinical or performance-based examination) compared to most people in the general population.
  - A clear rationale for the recommended accommodations and/or assistive devices.
- Informal or non-standardized assessment methods, if used, should be described in enough detail that other professionals in the field can understand their significance in the diagnostic process.
- If there is no prior history of accommodations, the qualified professional should

In This Section

4. Relevant objective records of impaired functioning

Additional Guidelines for Specific Impairments

- **Specific Learning Disorders**
- **Attention-Deficit/Hyperactivity Disorder (ADHD)**
- **Visual Impairments**
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Step 3

Test Accommodations

Reschedule an Exam

USMLE Updates & Research

Performance Data

Podcasts

Privacy

United States Medical Licensing Examination®

Guidelines

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2. A personal statement

3. A report of professional evaluation and/or appropriate records from a qualified evaluator/treating professional

4. Relevant objective records of impaired functioning

- Objective records of functioning should be submitted to document the real-world current impact of the disability and demonstrate how a major life activity relevant to the setting and context of the specific examination is substantially limited.
- Examples of supporting documentation include but are not limited to:
  - Prior clinical evaluations, diagnostic reports, treatment and/or educational plans, or other relevant medical records.
  - Written feedback from teachers or supervisors.
  - Official academic records and transcripts.

- Official score reports for nationally normed standardized tests (e.g., SAT, ACT, MCAT, LSAT, GRE, GMAT, professional licensing or certifying exams, etc.).
- Performance evaluations from training programs, military service, or employment settings (e.g., part-time/full-time volunteer/paid jobs, clerkship/internship/residency, etc.).
- Official records verifying approved accommodations from schools or other testing agencies listing the specific accommodations approved and dates that they were provided.

Additional Guidelines for Specific Impairments

- **Specific Learning Disorders**
- **Attention-Deficit/Hyperactivity Disorder (ADHD)**
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In This Section +

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Resources

Bulletin of Information

Announcements

Common Questions

Step Exams

Step 1

Step 2 CK

Step 3

Test Accommodations

Reschedule an Exam

USMLE Updates & Research

Performance Data

Podcasts

Privacy

Guidelines

General Guidelines to Request Test Accommodations

The following general guidelines are applicable to all disabilities and are provided to assist you in documenting a need for test accommodations based on an impairment that substantially limits one or more major life activities.

Requests for accommodations must include the following:

- **1. A completed and signed Request for Test Accommodations form**
- **2. A personal statement**
- **3. A report of professional evaluation and/or appropriate records from a qualified evaluator/treating professional**
- **4. Relevant objective records of impaired functioning**

Additional Guidelines for Specific Impairments

- **Specific Learning Disorders**

Attention-Deficit/Hyperactivity Disorder (ADHD)

In addition to the information described in the General Guidelines, a request for test accommodations on the basis of ADHD should include the following:

1. A report of evaluation by a qualified professional

- It is up to each professional to determine an appropriate assessment battery for any given evaluation.
- The professional report should generally include the following:
  - Relevant aspects of the individual's developmental, educational, family, medical, psychosocial, educational, occupational, and other personal history.
  - A history of the individual's presenting symptoms, with detailed information about how the symptoms have manifested in the home, school, work, and other settings over time.
  - Self-report symptom checklists, behavior rating scales, and continuous performance tests may be useful in diagnosing ADHD. Since adult recall of childhood symptoms tends to be unreliable, the evaluator should seek ancillary information from other sources (e.g., parent, teacher, spouse) as well as examples of current functional impairment in more than one setting.
  - A review of documentation from third-party sources, when available, to establish a history of impairment that goes beyond self-report (e.g., review of academic records; scores from prior standardized exams; previous evaluations or treatment records; feedback from teachers/faculty, advisors, supervisors; etc.).
  - A differential diagnosis with a discussion of how each possible alternative explanation for the identified problem(s) has been systematically ruled out.
  - A rationale for each recommended test accommodation.
  - If the report includes a comprehensive psychological, psycho-educational, or neuropsychological evaluation, it should adhere to current professional standards and include:
    - Actual scores obtained for each administered subtest and/or measure reported as age-based standard scores when available from the test publisher.
    - The specific version of each test (e.g., 4th Edition, etc.) along with the specific norms used for scoring (e.g., age-based norms).
    - A summary integrating all obtained test and assessment data with available clinical presentation, behavioral observations, relevant background/historical information, and current functioning to support the diagnostic conclusion.

- If there is no prior history of classroom or test accommodations, an explanation of why accommodations have not been required/provided in the past and why they are necessary at this time.

2. Objective records of impaired functioning
   - While historical records of childhood difficulties may not be obtainable in every case, providing objective documentation demonstrating a history of functional impairment in more than one setting is useful to demonstrate the developmental nature and course of the impairment(s) due to ADHD.
   - Records of current/recent real-world functional impairment in academic, social, and/or vocational settings and in daily adaptive functioning demonstrating how a major life activity is substantially limited.

Visual Impairments

Hearing Impairments

Psychiatric Disorders

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In This Section

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United States Medical Licensing Exam

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NBME.org

FSMB.org

Resources

Bulletin of Information

Announcements

Common Questions

Step Exams

Step 1

Step 2 CK

Step 3

Test Accommodations

Reschedule an Exam

USMLE Updates & Research

Performance Data

Podcasts

Privacy

Cookie Preferences

United States Medical Licensing Examination®

Home - Step Exams - Test Accommodations

Guidelines

General Guidelines to Request Test Accommodations

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Requests for accommodations must include the following:

1. A completed and signed Request for Test Accommodations form

2. A personal statement

3. A report of professional evaluation and/or appropriate records from a qualified evaluator/treating professional

4. Relevant objective records of impaired functioning

- Objective records of functioning should be submitted to document the real-world current impact of the disability and demonstrate how a major life activity relevant to the setting and context of the specific examination is substantially limited.
- Examples of supporting documentation include but are not limited to:
  - Prior clinical evaluations, diagnostic reports, treatment and/or educational plans, or other relevant medical records.
  - Written feedback from teachers or supervisors.
  - Official academic records and transcripts.

- Official score reports for nationally normed standardized tests (e.g., SAT, ACT, MCAT, LSAT, GRE, GMAT, professional licensing or certifying exams, etc.).
- Performance evaluations from training programs, military service, or employment settings (e.g., part-time/full-time volunteer/paid jobs, clerkship/internship/residency, etc.).
- Official records verifying approved accommodations from schools or other testing agencies listing the specific accommodations approved and dates that they were provided.

Additional Guidelines for Specific Impairments

Specific Learning Disorders

Attention-Deficit/Hyperactivity Disorder (ADHD)

Visual Impairments

Hearing Impairments

Psychiatric Disorders

In addition to the information described in the *General Guidelines*, a request for test accommodations on the basis of a psychiatric disorder should include the following:

1. **A report of evaluation by a qualified professional**
   - A comprehensive psychiatric or psychological evaluation should adhere to current professional standards (e.g., the current version of the American Psychiatric Association's Practice Guidelines for the Psychiatric Evaluation of Adults) and should include the following:
     - A description of the presenting problem(s) and symptoms, with details about the onset and history of symptoms, as well as their current frequency, severity, and duration, etc.
     - Information about the individual's current daily life activities (e.g., school, working, home, social, etc.) and day-to-day functioning relative

to most people.
    - Relevant aspects of the individual's history, with details regarding any past or present impact of psychiatric symptoms on academic, occupational, and social functioning.
    - It is up to each evaluator to determine an appropriate assessment battery for any given evaluation. Provide assessment data and findings from all diagnostic tests and measures administered. Examples of common tests and measures include:
        - Structured diagnostic interviews/clinical interviews (e.g., *Structured Clinical Interview for DSM-5 (SCID-5)*).
        - Standardized norm-referenced measures of cognitive or neuropsychological functioning.
        - Behavior or symptom rating scales (e.g., current versions of the *Yale-Brown Obsessive Compulsive Scale (Y-BOCS), Beck Depression Inventory (BDI), Multiscore Depression Inventory for Adolescents and Adults (MDI), Beck Anxiety Inventory (BAI), Depression Anxiety and Stress Scales 21, Minnesota Multiphasic Personality Inventory (MMPI), Conners' Adult Rating Scale, Achenbach Adult Self Report for Ages 18-59, Achenbach Behavior Checklist for Ages 18-59, Clinical Assessment of Depression, Test Anxiety Inventory*, or other scales for anxiety, mood, trauma, or related symptoms).
            - Rating scales and other diagnostic instruments are not meant to be used in isolation; no one measure is considered sufficient by itself to make a psychiatric diagnosis.
        - Symptom severity indices.
        - Objective tests of effort (e.g., symptom validity tests).
- A thorough summary that integrates test and assessment data with clinical presentation, behavioral observations, relevant background/historical information, and current functioning.
- Evidence of a differential diagnosis and a description of how each possible alternative explanation for the identified problem has been systematically ruled out.
    - For example, symptoms of the diagnosed psychiatric disorder must be distinguished from normal adult reactions and behaviors such as test anxiety, academic underachievement or failure, bereavement, personality traits, or low self-esteem.
- A specific diagnosis based on criteria for psychiatric disorders consistent with the most recent edition of the *Diagnostic and Statistical Manual of*

Mental Disorders (DSM) or the International Statistical Classification of Diseases and related Health Problems (ICD).

- A clear description of how the identified impairment and related symptoms are relevant to the specific examination setting and context.
- A rationale for each recommended test accommodation.

2. **Objective records of impaired functioning**
   - Records that reflect the individual's functioning in daily life activities (e.g., social, academic, occupational environments, etc.) since the onset of the psychiatric disorder and at the present time.
   - A report of evaluation or treatment summary completed **within the past six (6) months** is necessary to establish the extent of current impairment and need for accommodations at the present time.

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In This Section

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Test Accommodations

Reschedule an Exam

USMLE Updates & Research

Performance Data

Podcasts

Privacy